Pediatric Insight
Brought to you by the Child Health Advisory Council

Adaptive Leadership and Challenges

By: Danielle Laraque-Arena, MD, FAAP in collaboration with The Child Health Advisory Council

The principles and insights of the concepts of adaptive leadership and adaptive challenges are important in thinking about how leadership characteristics and processes can lead more effectively to tangible outcomes that improve health. Understanding of adaptive processes of complex organizations and situations may also be important for the individual leader, to alert them to their blind spots, and to display how integrating principles that are more persuasive in the path to transformational change can be achieved without the accompanying feeling that power is being relinquished. And for those leaders who are firm on equity principles the concept of fundamental, transformative change versus gradual change may be challenging.

What is Adaptive Leadership?

The concept of adaptive leadership and adaptive challenges was coined by Ronald A. Heifetz published in 1994.[1] His book entitled Leadership Without Easy Answers is set in four parts discussing Setting the Frame, Leading with Authority, Leading without Authority, and Staying Alive. The author emphasizes the point that adaptive leadership belongs to not only named leaders, but anyone who wishes to get something done – and in partnership with others. Some key learnings include the necessity of the application of theory and research to everyday problems. Research -e.g. in the biomedical arena may be distant initially from the ultimate aim of improving health. And while most clinicians and scientists accept the intrinsic value of knowledge without current known application the incredible medical technologies such as that of gene-editing represented by CRISPR (clustered regularly interspaced short palindromic repeats) alerts us to the imperative to be prepared for adaptive challenges.[2,3] Medicine is an applied field of science which should seek to answer everyday problems and pressing health concerns with evidence. The approach to leadership, by inference, should be principled but flexible with a keen understanding of the broader socio-economic-political context of the world we live in, intended and unintended consequences of interventions as well as the consequences of inaction. Conflicts of interest related to the current payment structures in the United States must also be dealt with and structural inequities addressed.

Adaptive leadership undertakes the following challenges that, as noted, have no easy answers. Those challenges exist within complex organizations which by definition have multiple stakeholders, thereby necessitating an understanding of the power dynamics in the navigation of complex interactions. Leadership often involves proposals for change and invoking the prospect of change may impose on those stakeholders a sense of loss, distress and disequilibrium ("shaking things up"). The process is inherently fueled also by trial and error needed to

arrive at comprehensive solutions to organizational challenges, and thus must specifically deal with stakeholder issues of identity, relationships and loyalties and avert the tendencies to cancel efforts of change. The principles of change management are well known to most and have some overlap with adaptive principles including the recognition that both emotional and situational components are at play.4 Deeply seated feelings and reactions place demands requiring time and patience. Understanding adaptive leadership challenges allows leaders to better interpret and respond to the tensions that lead to avoidance in tackling complex problems and the appeal of the status quo.[5-8] It is easier not to change.

Adaptive Leadership and Framing

The literature does point to the framing of a problem as critical to how relevant data are considered and lead to action intended to resolve a problem of interest. The authors Vanessa Northington Gamble and Deborah Stone examining US Policy on Health Inequities: The Interplay of Politics and Research exemplified how framing of the problem of health disparities might yield different actions and policies if the charge or framing of that problem were different.[9] We use the example of the charge given by the US federal government to address the problem of health disparities with a justice strategy. The Civil Rights Commission, the agency which investigates deprivations in civil rights when asked to tackle the issue of health disparities began by stating the root cause of inequities/disparities to be discrimination and lack of fairness. The process for the commission then extended to fact-finding, with the research seeking to understand when, where and how discrimination happens and how anti-discrimination law could be enforced. The outcome of this analysis yielded a clear directive to specified agencies and actors who could apply the findings to resolve the noted disparities. Contrast this with the same charge given to the Institute of Medicine (IOM) where the strategy was a scientific one. This process began similarly with accumulation of data. The framing of the causes of disparities in this scientific approach was seen as multiple and complex. The research aimed to untangle the causal factors necessary for action. The presumption was that scientific research was a prerequisite to effective policy action. The scientific analysis by the IOM in its document Unequal Treatment[10] did not, unlike the task given the Civil Rights Commission, give a directive to any specific agency whose responsibility it would be to resolve the problem of disparities in care. The outcomes of these approaches are discussed by Gamble and how the different framing approaches determine the timeline and the success of the resolution of the defined problem.

The contrast between technical versus adaptive work is relevant to the discussion on framing. In medicine many protocols and lines of authority have already dictated how medical issues are tackled. For example, the response to trauma (in hospital and out of hospital care) is well established with well-rehearsed protocols that have become the norm.[11] Development of these protocols may have at first been difficult and will likely continue to require refinement, but the basics have been established and become more technical in nature. But the response to new challenges – for example the COVID-19 pandemic, HIV/AIDS in the 80s and 90s, our response to racism – require organizational actions that are not so easy, create stressful situations, and require leadership to manage that disruption to arrive at creative, feasible and accepted solutions. Those in positions of authority may not have easy answers to these problems and may decide on inaction, avoidance, or maladaptive solutions.

A way out of this quandary is to step back and set the framing of the problem in a way that leads to clear directives for particular teams and agencies and invites a spirit of collaboration for the greater good. Dealing with tensions is not easy and socialization of the proposed solutions may lead to imposed delays in implementation or torpedoing of the entire change process. Adaptive leadership that is managed leads to adaptive work

with various levels of complexity. In one situation a technical solution is possible but needs to be implemented through a partnership in roles and responsibilities. In other situations, there may be neither a technical solution nor the implementation strategy, so leadership is needed to first frame the problem being addressed, learning is necessary to define that problem and then to create/implement the solution.

A useful concept in facing adaptive challenges is relayed in the decision quality chain. This chain begins by setting the appropriate frame as discussed, then exploring various creative alternatives, pulling in relevant and reliable data, examining the clear values and tradeoffs, applying sound reasoning and then most importantly committing to action.[12] The frame specifies the problem or opportunity to be addressed and as described by Spetzler, has three components to be addressed:

1. The purpose in making the decision;

2. The scope of what will be included or excluded;

3. The perspective on the problem.

Involvement of all the key stakeholders in this process is necessary and conversations are needed to illuminate participants thoughts for each of the components and to discuss alternatives that invite genuine conversations of the tradeoffs and the benefits. Consensus regarding the framing is essential in proceeding through the decision quality chain. Leadership is required to hold true to the commitment to action. Many strategic plans sit on a shelf with no real plan for action. Budgetary commitment needs to accompany any proposed solution for the community of stakeholders to believe that the commitment is credible.

Recognizing One's Blind Spots and Acceptance of Change as a Leader:

As leaders, we all have blind spots or beliefs that are so deeply held that it is hard to fathom a different course of action. The quality decision chain processes and the understanding of the challenges of adaptive leadership can allow discussion of alternative views that perhaps can be reconciled without betraying one's deeply held beliefs. Money, and the challenges of competing resources is one that must be tackled head on. Global budgeting methodologies that combine funding for clinical operations, research, education and community outreach can be arrived at through budget systems and policy, business plans and capital budgets, operating budgets of various fiscal units, and service line development to achieve a common goal.[13] Win-win situations can be derived from disciplined funding streams that invest in joint strategic funds to solve complex problems.

Summary: Leaders Must Lead

Transactional (Technical) versus Adaptive problems/challenges/opportunities, the former relates to administrative responsibilities that deal with expected, routine problems. These need to be done ethically and with precision but they don't generally involve innovation, risks and progressive learnings in complex situations. Facing more complex or novel problems requires courage, innovation, commitment to cognitive diversity, and accepting disequilibrium to arrive at novel solutions. Bold leadership with or without authority (that is then claimed) at all levels of the organizational hierarchy becomes essential.

Future challenges for divisions, departments, schools of medicine and public health, and health science universities is the reconciliation of priorities, global budgeting strategies, revised physician compensation models and a commitment to organizational justice and equity.[14-16] These challenges need to be met and centered around firm adherence to our collective purpose to improve both individual and community health.

References:

1. Heifetz RA. Leadership Without Easy Answers. Belknap Press of Harvard University Press. Cambridge, Massachusetts, London England. 1994.

2. Doudna JA. The promise and challenge of therapeutic genome editing. Nature; Vol 578, February 13, 2020; 229-236. https://doi.org/10.1038/s41586-020-1978-5

3. Baltimore D, Berg P, Botchan M, et al. A prudent path forward to genomic engineering and germline gene modification. Science. 2015, April 3: 348(6230):36-38. doi:10.1126/scine.aab1028

4. Campbell, Robert James EdD Change Management in Health Care, The Health Care Manager: 4/6 2020 - Volume 39 - Issue 2 - p 50-65 doi: 10.1097/HCM.0000000000000290

5. Laraque-Arena, D. Meeting the Challenge of True Representation in US Medical Colleges. JAMA Netw Open. 2019 Sep 4;2(9):e1910474. doi: 10.1001/jamanetworkopen.2019.10474. No abstract available. PMID:31483465.

6. Laraque-Arena D. Historically Black Universities and Medical Colleges-Responding to the Call for Justice. JAMA Netw Open. 2020 Aug 3;3(8):e2015246. doi: 10.1001/jamanetworkopen.2020.15246.

7. Laraque-Arena D, Fennoy I, Davidson LL. The Role of Academic Medicine in the Call for Justice. J Natl Med Assoc. 2021 Feb 24:S0027-9684(21)00022-5. doi: 0.1016/j.jnma.2021.01.007. Online ahead of print. PMID: 33640113.

8. AAMC, Learn Serve and Lead: The Virtual Experience. https://web.cvent.com/event/8fa9b960-2774-4d1e-941a-a7a28460bee7/websitePage:00d0787a-f2d7-46e4-be77-d1a8201d4af8

9. Gamble VN, Stone D. US Policy on Health Inequities: The Interplay of Politics and Research. Journal of Health Politics, Policy and Law. Vol 31, No 1. Feb. 2006. Duke University Press.

10. Smedley BD, Stith AY, Nelson AR, editors. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care Washington (DC): National Academies Press (US); 2003. PMID: 25032386. Bookshelf ID: NBK220358 DOI: 10.17226/12875.

11. LaGrone L, Riggle K, Joshipura M, et al. Uptake of World Health Organization's trauma care guidelines: a systematic review. Bull World Health Organ. 2016 Aug 1; 94(8): 585–598C. Published online 2016 May 13. doi: 10.2471/BLT.15.162214 PMCID: PMC4969985 PMID: 27516636

12. Spetzler C, Winter H, Meyer J. Decision Quality: Value Creation from Better Business Decisions. 2016, Strategic Decisions Grou International LLC. Published by John Wiley & Sons, Hoboken, New Jersey.

13. https://www.manatt.com/Manatt/media/Documents/Articles/AMC-Service-Line-Development-in-AHSs-January-2022_b.pdf

14. Colquitt JA. (2001). On the dimensionality of organizational justice: a construct validation of a measure. J Appl Psychol. 2001;86(3):386-400. doi: 10.1037/0021-9010.86.3.386.

15. Colquitt, J. A., & Rodell, J. B. (2015). Measuring justice and fairness. In R. S. Cropanzano & M. L. Ambrose (Eds.), The Oxford handbook of justice in the workplace (pp. 187–202). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199981410.013.8

16. Laraque-Arena D, Germain L, Young V, Laraque-Ho – Editors/Authors in Leadership at the intersection of Gender & Race in Healthcare and science: Case Studies and Tools, 2022, Routledge/Taylor & Francis, in production.